Department of Health and Human Services
Office of Inspector General
Areas of Concern
2000

Medicare Contractors

The Medicare program is administered by the Health Care Financing Administration (HCFA) with the help of 64 contractors that handle claims processing and administration. The contractors are responsible for paying health care providers for the services provided under Medicare fee-for-service, providing a full accounting of funds, and conducting activities designed to safeguard the program and its funds. There are two types of contractors -- fiscal intermediaries and carriers. Intermediaries process claims filed under Part A of the Medicare program from institutions, such as hospitals and skilled nursing facilities; carriers process claims under Part B of the program from other health care providers such as physicians and medical equipment suppliers. OIG work identifies several areas of concern.

Integrity Problems. Most troubling are those problems that relate to contractors' own integrity -- misusing government funds and actively trying to conceal their actions, altering documents and falsifying statements that specific work was performed. In some cases, contractors prepared bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts. In other examples, contractors adjusted their claims processing so that system edits designed to prevent inappropriate payments were turned off, resulting in misspent Medicare Trust Fund dollars. Since 1992, OIG investigations involving contractors have resulted in 4 criminal convictions, 9 civil adjudications, and over $242 million in fines, restitution and settlements. In addition, we have 23 former or current contractors actively under investigation.

Fraud Unit Performance. As part of their payment safeguard activities, Medicare contractors are required to have Fraud Units which are designed to detect and deal with problems of fraud and abuse within the provider community.

OIG's review of these units' operations found that effectiveness varies considerably and often performance is not directly related to the size of the unit or the total amount of resources allocated. Total case loads among the fraud units varied from zero to over 600 for the intermediaries. In reviewing carrier case files, we also found that some allegations of fraud were being lost during the overpayment adjustment process and were not properly developed as potential fraud cases.

Given the importance of the function, OIG is supportive of the new contracting authority granted to HCFA under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HCFA now has more flexibility in contracting for program integrity functions and may enter into

individual contracts or work orders for specific program safeguard functions, such as medical review, fraud detection, cost report audits, and reviews to identify primary payers to whom Medicare is the secondary payer. We look forward to the changes in Medicare contracting that are taking place under the new Medicare Integrity Program.

OIG Work: *Fiscal Intermediary Fraud Units,* OEI 3-97-00350
Medicare Carrier Fraud Units, OEI-05-94-00470

Financial Management Problems. For several years, OIG has reported problems in the Medicare contractors' financial management and accounting procedures and longstanding weaknesses in internal controls. In essence, financial systems were not integrated with their claims processing systems and lacked basic accounting features, such as a dual-entry general ledger system, adequate source documentation, and proper cutoff procedures.

Most recently, our audit of HCFA's FY 1998 financial statements again highlighted the need for improving contractor controls over Medicare accounts receivable, cash, financial reconciliations, and electronic data processing.

OIG Work: *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998,* A-17-98-00098

Accounts Receivable. We have been unable to give an unqualified opinion on HCFA's financial statements, in large part because the contractors lacked sufficient documentation to support the receivable amounts reported. Medicare accounts receivable primarily represent funds that medical care providers owe to HCFA due to overpayments, as well as funds due from other entities in instances in which Medicare is the secondary payer of claims. The Medicare contractors for FY 1998, reported over $22.9 billion of Medicare accounts receivable activity (overpayments added to the account during the year, plus collection of current and past year overpayments) with a net balance of $3.3 billion. This represents approximately 90 percent of the $3.6 billion total accounts receivable reported by HCFA at the year's end.

We found deficiencies in nearly all facets of Medicare accounts receivable activity at the 12 contractors reviewed. Some contractors were unable to provide documentation to support their beginning balances, others reported incorrect activity, including collections, and still others were unable to reconcile their reported ending balances to subsidiary records. For instance, two contractors had unreconciled differences in their reported ending balances of $44.7 million and $11.9 million, respectively. In addition, substantial amounts of receivables had been settled with insurance companies but were still presented as outstanding.

The HCFA has fully cooperated with all investigative and review efforts and has underway a major effort to correct the accounts receivable problem with the contractors.

OIG Work: *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998,* A-17-98-00098

***Electronic Data Processing*.** For FY 1998, HCFA relied on extensive data processing operations at the contractors to process and account for $176 billion in Medicare fee-for-service expenditures. The contractors use one of several shared systems to process and pay claims. The shared systems interface with HCFA's Common Working File to coordinate Parts A and B benefits and to approve claims for payment.

Our FY 1998 review found electronic data processing control weaknesses at 11 of the 12 contractors sampled. Some of these weaknesses were also reported the previous year but were not corrected. For example, we were able to penetrate the security systems and obtain access to sensitive Medicare data. Contractors were able to deactivate or bypass edits, such as those used to detect duplicate claims, in two shared systems. We noted instances in which duplicate claims were paid on the same day without detection by these edits. Some paid claims bypassed processing by the Common Working File, and management review of the bypass process needed to be improved.

Our Year 2000 audits also identified possible internal control weaknesses at the Medicare contractors, which we intend to address as resources become available. For example, we noted a possible, unauthorized system change which calls for further, more complete review. Due to a systems weakness at a Medicare contractor, we found that a hospital was paid twice, once under prospective interim payments and again through its monthly billings. The edit that caused this $20 million mistake was quickly fixed; however, we do not know whether this was an unauthorized system change that may occur again or whether similar situations exist at other contractors.

We also note that security issues will become even more critical as more and more applications move from the mainframe (and its centralized controls) to a LAN-based environment. Already some Medicare claims processing applications have moved to the LAN environment. Front-end EDP audit expertise becomes particularly critical as these systems are developed.

Because system controls guard against erroneous payment, it is difficult to quantify their value in terms of recovered overpayments or savings. However, the risk from failing to maintain a watchful presence brings with it the very real possibility that critical data, whether for policy or financial decisions, will lose its integrity and reliability.

OIG Work: *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998,* A-17-98-00098; *(numerous other internal reports)*

Medicare Equipment and Supplies

While Medicare payments for medical equipment and supplies represent a small proportion of the program (about $6 billion), over the years we have devoted significant resources to this area due

to the significant problems associated with the provision of this benefit. We have consistently reported on excessive Medicare reimbursement rates and recommended that the process for adjusting fee schedules be streamlined. The Balanced Budget Act gave HCFA limited authority to do just that. We are very pleased that HCFA, through the Durable Medical Equipment Regional Carriers, recently announced that they plan to reduce fee schedules for seven items. The Balance Budget Act also mandated surety bonds for providers of these services and HCFA has established an important new procedure to have site visits performed of every supplier applying to enroll as a Medicare medical equipment provider. These have been important steps. However, we believe that additional action should be taken to reduce payments for selected items, such as hospital beds. We continue to recommend requiring providers to pay an application fee to cover the cost of processing their applications to participate in the program. Our work in this area continues with studies related to blood glucose test strips, ventilators, orthotics, and the National Supplier Clearinghouse.

OIG Work: *Medicare Reimbursement for Hospital Beds in the Home* OEI-07-96-00221 and OEI-07-96-00222; *Medical Equipment Suppliers: Assuring Legitimacy* OEI-04-96-00240

Provider Numbers

Over the years, the OIG has identified significant programmatic weaknesses in the way that Medicare assigns and maintains provider numbers. Ensuring that only legitimate providers enter the program and provide services to Medicare beneficiaries is of paramount importance. The Balanced Budget Act provided a powerful tool by authoring Medicare to collect Social Security and tax identification numbers from providers. The Health Insurance Portability and Accountability Act also contained significant provisions related to administrative simplification which call for a national provider identification system. However, Medicare will not really be secure until these new systems are carefully implemented. We will closely monitor the implementation of the new statutory provisions to ensure that these systems work as intended.

We recently issued a report on Accuracy of Unique Physician Identification Number Data. We found that HCFA has taken meaningful actions to enhance the accuracy of data associated with Medicare's unique physician identification number (UPIN). This includes the planned periodic re-validation of provider information and shortened protocols to deactivate numbers not being used. However, despite these efforts, problems continue to exist with some UPIN data. Almost one-fourth of the numbers have no recent claims activity and some providers have a large number of active provider identification numbers associated with their UPIN. Our work in this area continues with studies underway to determine if excluded providers continue to provide services to Medicare beneficiaries.

OIG Work: *Accuracy of Unique Physician Identification Number Data*, OEI-07-98-00410

Medicare Payment Error Rate

For Fiscal Year (FY) 1998, the Department reported $176.1 billion in Medicare fee-for-service payments. To determine whether these payments were made in accordance with laws and regulations, we statistically selected 600 beneficiaries nationwide with 5,540 fee-for-service claims processed for payment during the year. Through detailed medical and audit review, we found that 915 claims did not comply with Medicare laws and regulations. By projecting these sample results, we estimated that FY 1998 net overpayments totaled about $12.6 billion nationwide, or about 7.1 percent of the total benefit payments.

These improper payments could range from inadvertent mistakes to outright fraud and abuse. It should be noted that the Medicare contractors' claims processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services as billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors we found.

The FY 1998 estimate is $7.7 billion less than the FY 1997 estimate of $20.3 billion and $10.6 billion less than the FY 1996 estimate of $23.2 billion — a 45 percent reduction. We attribute the decline to several factors, including the Medicare Integrity Program under which the Health Care Financing Administration (HCFA) expanded Medicare contractor safeguard activities. Other fraud and abuse initiatives also had a significant impact. In this regard, the Health Insurance Portability and Accountability Act provided both HCFA and OIG with the resources needed to step up fraud and abuse prevention efforts. Additionally, HCFA and OIG outreach activities were pivotal in improving documentation by health care providers for services claimed. In fact, documentation errors dropped from $10.8 billion in FY 1996 to $2.1 billion in FY 1998. While we are encouraged by this drop, continued efforts are needed to reduce the current estimate of over $9 billion in medically unnecessary and incorrectly coded services.

OIG Work: *Improper Fiscal Year 1998 Medicare Fee-for-Service Payments*, A-17-99-00099

Medicare Payments for Mental Health Services

We continue to be concerned about inappropriate Medicare payments involving mental health services in a variety of settings.

Community Mental Health Centers. In 1998, the OIG completed its five-State study of partial hospitalization program services provided in community mental health centers. This program is an intensive outpatient psychiatric program which provides services to acutely ill individuals in order to prevent their hospitalization. Medical reviewers found that over 90 percent of the Medicare payments ($229 million of $252 million) were for unallowable or highly questionable services. In addition, the cost reports at selected centers contained significant unallowable and

nonreimbursable items. Further, HCFA's enrollment initiative in nine States found that a high percentage of the nearly 700 centers covered did not meet certification requirements to qualify for Medicare payments.

To address these problems, HCFA developed a 10-point plan. To date, HCFA has reported approximately 150 centers as terminated (this includes voluntary terminations and cessation of business). The HCFA has issued instructions to fiscal intermediaries on intensified medical review and provider education, and an initial site visit is conducted at each new center. As part of its long-term goals, HCFA is implementing a prospective payment system for partial hospitalization program services, has conducted a broad evaluation of the benefit, and has started the process of deactivating billing numbers for centers that have not billed Medicare within 6 months.

OIG Work: *Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers,* A-04-98-02145

Hospital Outpatient Departments. We are currently reviewing psychiatric services rendered on an outpatient basis at acute care hospitals. Our ongoing 10-State review found that $224 million of the approximately $382 million claimed for outpatient psychiatric services was for unallowable or unsupported services.

We statistically selected for review 200 claims, totaling $168,857, from providers in the 10 States. These services were charged on behalf of patients in partial hospitalization programs and those receiving other outpatient psychiatric services. Our analyses showed that about $94,000 of these charges did not meet Medicare criteria for reimbursement. The services were not documented in accordance with Medicare requirements, not reasonable and necessary, rendered by unlicensed personnel, rendered off-site, or not adequately supervised by a physician. Based on our statistical sample, we estimate that for Calendar Year 1997, acute care hospitals submitted claims to Medicare totaling $224,466,692 (approximately 58.8 percent of the amount claimed) for unallowable or unsupported outpatient psychiatric services in the 10 States reviewed.

We are currently completing in-depth reviews of outpatient psychiatric services provided by 10 acute care hospitals and 5 psychiatric hospitals. Included will be medical record reviews to determine whether allowable and supportable services were provided as well as reviews of costs claimed on each provider's cost report.

Also, we are conducting a 10-State review of outpatient psychiatric services at psychiatric hospitals. In 1998, psychiatric hospitals nationwide charged Medicare approximately $182 million for outpatient psychiatric services. Providers in California, New York, Massachusetts, Illinois, Florida, Louisiana, Texas, Pennsylvania, Connecticut, and the District of Columbia accounted for 82 percent of these charges, or approximately $149 million. The 10-State review will indicate whether the Medicare program incurred financial losses because psychiatric hospitals received payments for services and costs that did not meet Medicare eligibility and reimbursement requirements.

OIG Work: *Ten-State Review of Outpatient Psychiatric Services at Acute Care Hospitals, (draft)* A-01-99-00507; *Review of Outpatient Psychiatric Services Provided by the Waterbury Hospital for Fiscal Year Ending September 30, 1997,* A-01-99-00501; *Review of Outpatient Psychiatric Services Provided by the Elliot Hospital for the Fiscal Year Ending June 30, 1999,* A-01-99-00502

Mental Health Services in Nursing Homes and Ambulatory Care Settings. In 1996, we examined the provision of mental health services to nursing facility residents. We found that for 32 percent of the records reviewed, Medicare paid for medically unnecessary mental health services in nursing homes. Certain types of procedures, such as group therapy and psychological testing, were more likely to be associated with unnecessary and questionable services. We also noted that lesser skilled people than clinical psychologists and psychiatrists provided services, for psychotherapy in particular. We recommended that HCFA take steps to prevent inappropriate payments for mental health services in the nursing home setting. We are conducting a follow-up study in CY 2000 to determine what steps have been taken. We are also conducting a similar study of mental health services in ambulatory care settings.

OIG Work: *Medicare Payments for Mental Health Services in Nursing Facilities*, OEI-02-91-00860

Medicare Payments for Rehabilitation Services

The Medicare program provides coverage and payment for physical, occupational, and speech therapy services that are reasonable and necessary to treat an individual's illness or injury. These services are provided in a variety of settings, including nursing homes, various rehabilitation facilities, and outpatient departments of hospitals. In recent years, these services have been the subject of intensive scrutiny by policy makers because of their concerns about the cost and possible abuse of these benefits. For example, the Balanced Budget Act of 1997 imposed annual caps of $1500 per Medicare beneficiary on physical therapy and on the combined package of occupational and speech therapy. It also folded the cost of these therapies into a new Medicare prospective payment system for nursing homes, also authorized by the same Act. Policy makers have been following developments in these new provisions closely out of concern that these new payment frameworks would not deprive Medicare beneficiaries access to these services. Most recently, in its 1999 amendments to the 1997 Balanced budget Act, the Congress suspended the therapy caps for two years, while asking the Secretary of Health and Human Services to study trends in therapy care and develop alternative payment controls. At the same time, it declined to substantially modify the nursing home prospective payment system with respect to the amounts allowed for therapy patients.

During this period, the OIG has been carefully studying these therapy services through audits and evaluations. We have been finding through these studies that Medicare patients benefit from the

therapy they receive, but a significant portion is not medically necessary or is improperly administered.

For example, we found that 13 percent of physical and occupational therapy given to Medicare patients in nursing homes in 1998 were not medically necessary or was provided by individuals who did not have the proper skill to do so. The cost of these improper payments was $1 billion. Our reports recommended that HCFA instruct Medicare fiscal intermediaries to provide more training to facility and therapy staff on Medicare coverage criteria and guidelines, local medical review policies, and monitoring procedures for therapy, work collaboratively with the national therapy and nursing home associations to assure that they provide accurate and comprehensive information to their members, and adequately fund Medicare contractors to perform medical reviews of therapy. The HCFA agreed with the recommendations and the Congress passed legislation in 1999 mandating focused medical reviews of therapy services, especially in nursing homes.

OIG Work: *Physical And Occupational Therapy in Nursing Homes: Medical Necessity and Quality of Care,* OEI-09-97-00121; *Physical And Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare,* OEI-09-97-00122

At the same time, we studied the impact of the new nursing home prospective payment system on access to care. We found that Medicare patients are able access care in nursing homes, particularly therapy patients. In fact, we found that it was easier to place Medicare therapy patients in nursing homes after the new payment system went into effect than before. Thus, the 1999 amendments to the 1997 Balanced Budget Act properly upheld the payment rates for therapy patients while adjusting other categories upward to account for the cost of high intensity care for some patients.

OIG Work: *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities*, OEI-02-99-00400

We are continuing our studies of therapy services provided in nursing homes to ensure that waste and abuse are prevented while necessary services are rendered. But we are also looking at these services in other settings, where we are also finding some problems.

The OIG has an ongoing six-State review of outpatient rehabilitation facilities in Florida, Louisiana, Michigan, New Jersey, Pennsylvania, and Texas, which accounted for about 50 percent of the total outpatient rehabilitation facility payments nationwide during CY 1997. Our results to date indicate that Medicare fiscal intermediaries may have paid the facilities over $170 million for unallowable or highly questionable services for the 12 months ending June 30, 1999. We are also conducting reviews of eight individual facilities.

OIG Work: *Six-State Review of Outpatient Rehabilitation Facilities, (draft)* A-04-99-01193

Additionally, the OIG is currently planning a review of therapy services provided in outpatient departments of acute care hospitals. We will identify those States that account for 50 percent or more of the charges for outpatient therapy services. We will select a statistically valid sample of claims and request medical record reviews to determine whether the therapy services provided were reasonable and necessary for the patient's illness or injury.

We have also identified the top 100 hospitals in the United States based on Medicare payments, and we plan to select a number of these hospitals for individual reviews.

Medicare Managed Care

Managed care plans, such as managed care organizations, provide comprehensive health services on a prepayment basis to enrolled individuals. Medicare beneficiaries have the option to enroll in these plans, which contract with HCFA to furnish all medically necessary services covered under the Medicare program. Medicare enrollment in managed care plans has been steadily increasing. In January 1993, 177 plans with Medicare contracts serviced 2.5 million beneficiaries. In October 1999, 409 plans had approximately 7 million Medicare enrollees. Medicare payments to managed care plans have also grown significantly--from $8.6 billion in Fiscal Year (FY) 1993 to $37.2 billion in FY 1999. By the year 2002, it is projected that 18.7 percent of the Medicare population will receive their medical services through some form of managed care plan. As a result of the actual and anticipated growth in the use of these plans, greater management attention is being devoted to their operations.

The OIG has been watching the development of this new approach to medical care and have raised some concerns through our audits and evaluations. These concerns center on Medicare payment rates, which we believe may be excessive, and on quality of care issues. Some of our most recent work includes the following.

Enhanced Payments to Managed Care Organizations. Our past audits demonstrated that HCFA did not have effective controls over the higher capitation payments to MCOs for beneficiaries with either end stage renal disease (ESRD) or dually eligible (Medicare and Medicaid) status. Currently, we are reviewing the extra payments made for beneficiaries with institutional status. We are also determining whether past problems with properly identifying ESRD and dually eligible beneficiaries have been corrected.

> ***OIG Work:*** *Review of HMO Payments - Beneficiaries on Dialysis,* A-14-98-00211; *other work in process*

Adjusted Community Rate Proposals. Section 1857(d)(1) of the Balanced Budget Act of 1997 requires that one-third of the adjusted community rate proposals submitted by MCOs that contract with HCFA be audited. The proposals are designed for managed care plans to present to HCFA their estimate of funds needed to cover the costs of providing a Medicare package of

covered services to an enrolled Medicare beneficiary. The HCFA initiated a new proposal process effective January 2000. At HCFA's request, we will audit a number of the proposals for Calendar Year 2000.

Fee-for-Service Payments to Disenrolled Beneficiaries. The HCFA analysis of how well a MCO performs does not include reviewing fee-for-service payments made for beneficiaries after they have disenrolled from the managed care organization. We will analyze the medical services received by these disenrolled individuals to determine if the managed care organizations may have encouraged their disenrollment and/or provided poor care.

OIG Work: *Review of Inpatient Services Performed on Beneficiaries After Disenrolling from Medicare Managed Care,* A-07-98-01256

Administrative Costs. Risk-based HMOs receive a large amount of funds for administrative costs to operate their Medicare managed care programs. The HCFA has very little information available on how the HMOs used these funds, which are provided as part of the Medicare capitation amount. We are analyzing the variances in administrative funds (as a percentage of total funds received from Medicare) among HMOs. Also, through our "scrub audits," we are reviewing how the HMOs use these funds.

OIG Work: *Review of the Administrative Cost Component of the Adjusted Community Rate Proposal at Nine Medicare Managed Care Organizations for the 1997 Contract Year,* A-03-98-00046

Withdrawal of Managed Care Organizations from Medicare. Recently, a number of MCOs have indicated that they will withdraw from participation in Medicare. We plan to study the impact of these withdrawals on beneficiaries, including the adequacy of notification, availability of other health care options, and extent of costs to beneficiaries associated with these changes.

Dissatisfaction of Vulnerable Beneficiaries.. Although beneficiaries, in responding to OIG surveys, reported generally positive experiences with HMOs, some indicated that they disenrolled because they received a lower standard of health care or because they felt their health had declined while in the HMO. This was particularly true of disabled beneficiaries and those with functional impairments and serious illnesses, who reported much less positively about their experiences. We also found some problems in communications between the HMOs and beneficiaries related to appeals and grievances.

OIG Work: *Beneficiary Perspectives of Medicare Risk HMOs 1996,* OEI-06-95-00430; *Medicare HMO Appeal and Grievance Processes: Overview,* OEI-07-94-00280

We have also examined how well informed Medicare beneficiaries are of the choices that are available to them under the managed care option of Medicare. In one study we found that the

HCFA's goals to expedite the marketing-material review process, reduce re-submissions of material, ensure uniform review across the nation, and most importantly, provide beneficiaries with accurate and consumer-friendly marketing materials to help them make informed health care choices were not completely met. Some of the marketing materials which we examined were hard to understand. We are now examining the "extra" benefits offered by managed care plans to Medicare beneficiaries as an inducement for them to enroll in the plans. Our study will assess the value which Medicare beneficiaries place on such things as prescription drugs, physical exams, and vision care which are not available under the Medicare fee for service program, but which are often offered und managed care plans, and how well they understand the scope and conditions of these benefits.

OIG Work: *Medicare Managed Care: Goals of National Marketing Guide*, OEI-03-98-00270/00271; *other work underway*

Home Health

The 1990's saw dramatic increases in Medicare payments for home health services, growing from $3 billion to almost $20 billion during this period. Some of this growth was due to the legitimate need for and the value of these benefits for homebound Medicare beneficiaries. But, we also saw signs that a fraud, waste, and abuse were also significant contributors. Because of the rapid growth and inherent vulnerabilities of this program, we undertook an extensive body of work, including investigations, audits, and evaluations, to gain a better understanding of it.

We found the home health benefit to be a program that grew too quickly with inadequate controls. The inability of Medicare to effectively identify improper claims before payment combined with the ease of entry of home health agencies into the program makes the Medicare trust fund especially vulnerable to losses from the home health program. For example, a 1997 audit disclosed that 40 percent of the claims sampled in four of the most populated States should not have been reimbursed. This extremely high error rate is consistent with errors detected in numerous provider-specific onsite audits conducted by teams of OIG auditors and intermediary medical review staff.

Fortunately, most of the vulnerabilities have been addressed by the Balanced Budget Act of 1997 and in subsequent Department regulatory and administrative initiatives. These solutions are now being implemented through the development of a prospective payment system, increases in the number of audits, more thorough enrollment and re-enrollment procedures, and various new penalties for abusive actions. Additionally, as the home health agencies themselves are best positioned to guarantee the integrity of their product, we recently issued a “Compliance Program Guidance for Home Health Agencies” to assist them in developing specific measures to combat fraud, waste and abuse, as well as in establishing a culture of ethics that promotes prevention, detection, and resolution of instances of misconduct.

To determine whether these program changes were having a positive impact on Medicare reimbursement, we recently replicated our 4-state review. Our report revealed that the error rate had, in fact, been significantly reduced, down from 40 to 19 percent. Although this reduction indicates notable progress, a 19 percent error rate is still too high and we are still far from finished with the task of reforming the home health program. Until all the recent reforms are fully implemented, the Medicare home health program will remain a serious risk. Therefore, we will continue to closely monitor the program.

The most fundamental home health reform brought about by the Balanced Budget Act is the establishment of a perspective payment system for the home health benefit. However, efforts to remedy the Year 2000 computer problem have delayed the PPS implementation date and therefore prolonged the period when the interim payment system is in effect. Although the interim system does address previous inappropriate incentives for excess utilization, some vulnerabilities which will be addressed by the prospective payment system will remain in force longer than intended.

The interim payment system has also created new incentives; under this system home health agencies have an incentive to stay below the new and reduced payment limits by reducing their costs per visit and by limiting the number of high cost patients. Because of this, concerns were raised as to whether this system so adversely affected home health agencies that they were unable to care for all Medicare patients needing home health services. However, we found that these concerns are not well supported. In a recent inspection, we found that 85 percent of hospital discharge planners were able to place their patients who need home care with home health agencies. Fifteen percent reported that they were not always able to place home health patients but usually this was only a small number of patients, and the reasons for their difficulties were related to general Medicare eligibility rules rather than the new payment rate. They also reported that home health agencies were screening out the more expensive care cases. Just over a quarter of discharge planners voluntarily reported concerns that, once placed, some home health patients were not receiving the adequacy of care they need. We will therefore continue to monitor this program closely, including conducting audits and investigations, as appropriate.

The lack of physician involvement in identifying their patients' needs and homebound status was a leading cause of the unallowable services disclosed by our previous reviews of this program. This is one weakness in the system which is not adequately addressed in recent reforms. We believe that physicians should play a prominent role in determining the need for and the appropriate level of home health services for beneficiaries and we continue to recommend that the role of the physician in supervising home health services be strengthened. While a physician must sign the plan of care for home health services, we have found that too often physicians do so without having examined the patient or do so at the request of a home health organization that "recruited" the patient. Options include: a requirement that the physician examine the patient before certifying the plan of care; increased educational efforts for physicians; modifications of the plan of care to spell out more clearly Medicare's eligibility requirements and provide an attestation by the physician that he or she is aware of these requirements and of the patient's condition.

The Balanced Budget Act also required that each Medicare home health agency acquire a surety bond subject to a minimum amount. Because of industry concerns over particular elements in the surety bond rules, and at the urging of some members of Congress, HCFA suspended the surety bond regulation while these problems can be worked out. We continue to believe that some type of surety bond is necessary to discourage fly-by-night providers from entering the program and to provide for some continuing financial protection to the Trust Fund from risks inherent in this program. The amount of the bond should be related to the experience of individual home health agencies as well as to the home health industry as a whole and the surety bond rule should be subject to periodic evaluation to gauge its effect on the Medicare program and its beneficiaries and providers.

Additionally, we are still concerned about medical care providers' (including home health agencies') ability to use bankruptcy protection as a way to avoid responsibility for repayment of overpayments, fines, or penalties, and in some cases even circumvent a program exclusion. We continue to support legislation to close these loopholes.

Overall, we are continuing to watch this program closely to ensure that the new reforms are implemented to eliminate waste and fraud while protecting access to care for Medicare beneficiaries.

OIG Work: *Medicare Beneficiary Access to Home Health Agencies,* OEI-02-99-00530, 11/99; *Home Health: Problem Providers and Their Impact on Medicare* OEI-09-96-00110, 7/97; *The Physician's Role in Home Health Care* OEI-02-94-00170, 6/95; *Variation Among Home Health Agencies in Medicare Payments for Home Health Services* OEI-04-93-00260, 7/95; *Geographical Variation in Visits Provided by Home Health Agencies* OEI-04-93-00262, 9/95; *Review of Medicare Home Health Services in California, Illinois, New York, and Texas* A-04-99-01194,11/99; *Operation Restore Trust: Audit of Medicare Home Health Services in California, Illinois, New York and Texas* A-04-96-02121, 7/97; *Review of Costs Claimed by Eddy Visiting Nurse Association of the Capital Region,* A-02-97-01026; *Review of Costs Claimed by Dr. Pila Foundation Home Care Program in Ponce, Puerto Rico,* A-02-97-01034; *Review of Home Health Claims Submitted by First American Health Care, Inc., Pennsylvania,* A-03-95-00011; *Review of Costs Claimed by St. Johns Home Health Agency,* A-04-94-02078; *Results of the Audit of Medical Home Health Services in Florida,* A-04-94-02087; *Review of Costs Claimed by Visiting Nurses Association of Dade County, Inc.,* A-04-95-01103; *Review of Costs Claimed by American Health Care Services,* A-04-95-01104; *Review of Costs Claimed by Home Health Services of South Florida, Inc., d/b/a USA Home Health Services,* A-04-95-01105; *Review of Costs Claimed by Pro-Med Home Health, Inc.,* A-04-95-01106; *Review of Costs Claimed by Home Health Care, Inc.,*A-04-95-

01107; *Review of Costs Claimed by Staff Builders Home Health Care, Inc.*, A-04-97-01166; *Review of Costs Claimed by Med Tech Home Health Services, Inc.*, A-04-97-01169; *Review of Costs Claimed by MedCare Home Health Services, Inc.*, A-04-97-01170; *Review of Costs Claimed by Homebound Medical Care, Inc.*, A-04-98-01184; *Review of Medicare Home Health Services in California, Illinois, New York, and Texas,* A-04-99-01194

Implementation of Balanced Budget Act Provisions

The Balanced Budget Act of 1997 instituted one of the most sweeping sets of changes to Medicare since the program's inception. The law literally made hundreds of changes to the program. We were very pleased that many of these reforms were consistent with recommendations made by our office or were aimed at correcting program weaknesses and vulnerabilities identified by OIG work. The following is a list of some of the more significant changes contained in the law:

-- Developing a prospective payment system for skilled nursing facilities that covers most nonprofessional services rendered during Part A covered stays.

OIG Work: *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities*, OEI-02-99-00400; *Review of the Health Care Financing Administration's Development of a Prospective Payment System for Skilled Nursing Facilities,* A-14-98-00350

-- Requiring nursing homes to directly bill Medicare for most services rendered to Medicare beneficiaries. This is commonly referred to as "consolidated billing."

OIG Work: *Skilled Nursing Facility Therapy Services Under Part B of Medicare*, OEI-09-99-00490

-- Requiring that a prospective payment system be developed for home health related services and that an interim payment system be utilized to control costs and utilization prior to implementation of the program.

-- Instituting a great number of program safeguard provisions, including requiring surety bonds for certain providers, recertifying the hospice benefit for longer term patients, and strengthening civil monetary penalty and exclusion authorities.

OIG Work: *Medicare Hospice Beneficiaries: Services and Eligibility*, OEI-04-93-00270; *Medical Equipment Suppliers: Assuring Legitimacy*, OEI-04-96-00240

-- Vastly expanding the health care options available to beneficiaries by creating the Medicare+Choice program.

-- Mandating that the Department redesign the way Medicare reimburses ambulance services through "negotiated" rulemaking.

OIG Work: *Medicare Payments for Ambulance Services: A Framework for Change*, OEI-12-99-00280; *Medicare payments for Ambulance Services - Comparisons to Non-Medicare Payers*, OEI-09-95-00411

-- Making a whole list of reimbursement changes including but not limited to those related to Medicare prescription drugs, therapy services and oxygen.

OIG Work: *Comparing Drug Reimbursement: Medicare and the Department of Veterans Affairs*, OEI-03-97-00293; *The Impact of High-Priced Generic Drugs on Medicare and Medicaid*, OEI-03-97-00510; *Are Medicare Allowances for Albuterol Sulfate Reasonable?*, OEI-03-97-00292; *Excessive Medicare Payments for Prescription Drugs*, OEI-03-97-00290; *Usage and Documentation of Home Oxygen Therapy*, OEI-03-96-00090

-- Authorizing Medicare payments for a variety of preventive services including mammography, pap smear and pelvic exams, prostate cancer screening, and colorectal screening.

-- Allowing Medicare to be a more prudent purchaser of services by authorizing competitive bidding and "inherent reasonableness" payment reductions.

OIG Work: *numerous OIG reports and testimony*

These provisions are quite impressive in their scope and their significance. Due to Y2K efforts, HCFA has delayed implementation of ceratin reforms by their statutorily mandated dates, including consolidated billing in nursing homes, home health prospective payments, and the ambulance fee schedule. We continue to believe that it is important to monitor the progress of implementation of these provisions and to examine their impact.

Nursing Facilities

The Balanced Budget Act of 1997 enacted payment reforms for nursing facilities with a prospective payment system for Part A skilled nursing facility stays and a consolidated billing provision. Full implementation of both reforms are important to controlling fraud and abuse in

nursing homes. The prospective payment system and consolidated billing for beneficiaries in a covered Part A stay have now been implemented. This year we examined the early effect of the prospective payment system on beneficiary access to skilled nursing care. We found that hospital discharge planners were able to place Medicare beneficiaries in nursing homes after implementation of the prospective payment system. We will continue to monitor implementation of these provisions to ensure that they are working as intended.

The implementation of consolidated billing for Part B services has been delayed until Y2K compatibility of Medicare billing systems is assured.

As noted earlier, provisions of therapy services in nursing homes is an area of interest to the OIG. We issued reports this year that found that before implementation of the prospective payment system, most nursing home residents were appropriate candidates for and benefitted from physical and occupational therapy they received. However, 13 percent of therapy was improperly billed and 4 percent was not documented in patient records. The costs of the improperly billed services was $1 billion in 1998.

In addition, the OIG reviewed infusion therapy services provided by some suppliers to skilled nursing facilities. Our audit found that suppliers charged excessive prices for infusion therapy, provided unnecessary services to patients, and improperly billed for services that the nursing facilities, in turn, misclassified on the Medicare cost reports. We are concerned not only about the financial effects of the overpayments we identified but also about overutilization and underutilization of therapy services.

The abusive practices related to both therapy and infusion may have resulted in inflated base-year costs on which the perspective payment system rates were based, causing the prospective payment system to be inflated.

We continue to be concerned about the quality of care in nursing homes. The Omnibus Budget Reconciliation Act of 1987 created a comprehensive set of nursing home reforms. The OIG is in its second year of a systematic examination of the implementation of the nursing home reform provisions of the OBRA 87. This year we examined the conditions in nursing homes and the systems that are intended to provide protection to nursing home residents. We found serious problems of quality of care, including bed sores, accidents, and nutrition problems. We also assessed the availability and usefulness of the survey results to nursing home residents and their families. We are currently examining: the role of the nursing home medical director in ensuring quality of care; the nursing home resident assessment's impact on quality of care; family member experience and satisfaction with nursing home care; and the extent to which financial screening and distinct part rules affect access to nursing homes for Medicare and Medicaid beneficiaries.

Finally, we also are concerned about a potential crisis looming in the nursing home industry due to the bankruptcy filing of two national nursing home chains and the reported financial difficulties of others. Vencor, Inc., which operates about 300 nursing homes, and Sun Healthcare Group,

another large chain with 385 facilities, recently filed for Federal bankruptcy protection. Reportedly, other national nursing home chains have posted large losses in recent months, adding to concerns of an industry-wide problem. We will continue to closely monitor this situation.

OIG Work: *Early effects of the Prospective Payment System on Access to Skilled Nursing Facilities*, OEI-02-99-00400; *Early effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators' Perspectives*, OEI-02-99-00401; *Effects of the Prospective Payment System on Access to SNFs for Patients With ESRD*, OEI-02-99-00402; *Physical and Occupational Therapy Services in nursing Homes: Quality of Care and Medical Necessity for Medicare Patients*, OEI-09-97-00121; *Physical and Occupational Therapy in nursing Homes: Costs of Improper Billings to Medicare*, OEI-09-97-00122; *Skilled Nursing Facility Therapy Services Under Part B of Medicare*, OEI-09-99-00490; *Nursing Home Survey and Certification: Overall Capacity*, OEI-02-98-00330; *Nursing Home Survey and Certification: Deficiency Trends*, OEI-02-98-00331; *Long Term Care Ombudsman Program: Complaint Trends*, OEI-02-98-00350; *Long term Care Ombudsman Program: Overall Capacity*, OEI-02-98-00351; *Public Access to Nursing home and Certification Results*, OEI-06-98-00280**;** *Infusion Therapy Services Provided in Skilled Nursing Facilities*, A-06-99-00058

Child Support Enforcement

In 1995, the Office of Inspector General began to investigate violations of the Child Support Recovery Act. This Act, which was enacted in 1992, makes it a Federal offense for a non-custodial parent residing in a different State than the child(ren) to willfully avoid paying his/her court ordered child support obligations. Since 1995, the OIG has opened over 680 cases and arrested over 250 individuals. As a result of these efforts, 147 individuals have been sentenced and over $10.2 million ordered in restitution.

Additionally, in conjunction with the Office of Child Support Enforcement, the OIG has created and established multi-agency, multi-jurisdictional task forces to identify, investigate and prosecute the most egregious criminal non-support matters at both the State and Federal levels. These task forces are headquartered in Columbus, Ohio; Baltimore, Maryland; and Dallas, Texas, and cover 11 States and the District of Columbia. Two other task force sites, headquartered in New York City and Sacramento, California, will be operational in the near future. These two additional task forces will cover an additional six States. The task force membership is comprised of criminal justice and social service personnel at the Federal and State levels. To date, the task forces have received over 1200 cases from the State child support agencies. These have resulted in over 270 arrests and 220 convictions or civil adjudications with over $5.3 million in restitution ordered.

We also have ongoing work in the area of child support enforcement. We are currently:

-- examining State methods for establishing paternity and describing how these determinations are used within the child support enforcement system;

-- assessing criteria used by child support agencies to determine client cooperation in establishing child support orders, including use of provisions which release clients from cooperation standards such as "good cause";

-- examining the alignment of original child support orders with the earnings of non-custodial parents, the policies and procedures that affect alignment of orders with earnings, and the relationship of order alignment to payment compliance;

-- conducting a follow-up study to determine if State Child Support Enforcement agencies have made progress in the detection of available dependent health insurance and the coordination of this information with State Medicaid agencies; and

-- determining State efforts in providing job training to noncustodial parents, thus enabling them to obtain or improve earnings and to increase child support payments.

Medicare Prescription Drugs

While Medicare does not pay for over-the-counter or many self-administered drugs, it does pay for certain categories of prescription drugs used by Medicare beneficiaries. Since 1992, Medicare outlays for prescription drugs have grown dramatically, increasing from $663 million to $2.3 billion in 1996. Prior to January 1, 1998, Medicare payments were based on "average wholesale prices (AWP)" which are mainly provided by manufacturers but bear little relationship to actual wholesale prices. Under provisions of the Balanced Budget Act of 1997, allowances are now based on a 5 percent discount of the published AWP. Based on our work, we believe that Medicare continues to substantially overpay for these drugs. We believe that additional legislative action or more extensive use of "inherent reasonableness" payment authorities is warranted to reduce outlays for prescription drugs. Legislative options include basing allowances on acquisition costs, mandating rebates, and permitting/requiring competitive bidding. We believe that such actions could save Medicare almost $800 million annually, depending upon the option adopted.

OIG Work: *Excessive Medicare Payments for Prescription Drugs* OEI-03-97-00290; *Comparing Drug Reimbursement: Medicare and the Department of Veterans Affairs* OEI-03-97-00293

Year 2000 Computing Problem

For the past 3 years, the Department has been diligently identifying and remediating its mission-critical systems. The HCFA is currently reviewing the recertification statements received to date from Medicare contractors attesting to the millennium readiness of their critical systems; statements from the remaining six contractors are due December 1. The HCFA had already taken action to:

-- resolve all qualifications that contractors made to their initial certifications; and

-- ensure that all system changes made subsequent to the initial certifications did not negatively affect the systems' millennium readiness.

The HCFA's remediation effort included onsite monitoring, use of an independent validation and verification contractor, establishment of a "war room" to address Y2K issues and dissemination of numerous guidelines on certification and recertification. As a consequence, HCFA believes that while some minor problems may occur, the Medicare claims processing systems will not be subject to a Y2K system failure. Further, while again some minor problems may occur, nothing has come to our attention to indicate that other departmental mission-critical systems will suffer a Y2K system failure.

OIG Work: *numerous OIG testimony and internal reports*